

**State of New Mexico
Benefits Comparison Guide**

	A	B	C	D	E	F	G	H	I	J
1	BENEFITS	PRESBYTERIAN- STATE OF NM 2023		BLUE CROSS BLUE SHIELD-STATE OF NM 2023			CIGNA-STATE OF NM 2023			
2	<small>This is only a summary that lists the employees' cost-sharing amounts and provides a brief description of the State of NM Group Plan benefits. The Summary Plan Description supersedes any information outlined in this summary.</small>	Tier 1	Tier 2	HMO	Tier 1 Provider	Tier 2 Provider	Tier 3 Provider	OAPIN (HMO)	OAP (PPO)	
3		Click for Premium Rate		Click for Premium Rates			Click for Premium Rates			
4		Preferred Network	National HMO Network	IN-Network	Blue Preferred Plus (NBP)	Preferred (PPO)	Nonpreferred (OON)	IN-Network	PREFERRED PROVIDER	NONPREFERRED PROVIDER
5		Deductibles	\$350 / \$700 / \$1050	\$500 / \$1000 / \$1,500	\$425 / \$850 / \$1,275	\$500 / \$1,000 / \$1,500	\$700 / \$1400 / \$2100	\$3,000 / \$6,000 / \$9,000	\$500 / \$1,000 / \$1,500	\$750 / \$1,500 / \$2250
6	Out of Pocket (combined Pharmacy & Medical)	\$3,750 / \$7,500 / \$11,250	\$4250 / \$8500 / \$12,750	\$4,000 / \$8,000 / \$12,000	\$4,000 / \$8,000 / \$12,000	\$5600 / \$11,200 / \$16,800	\$9,000 / \$18,000 / \$27,000	\$5,000 / \$10,000 / \$15,000	\$5,000 / \$10,000 / \$15,000	\$9,000 / \$18,000 / \$27,000
7	Lifetime Maximum (Certain services are subject to Plan Year and/or lifetime maximums or are limit per condition.)	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
8	Primary Care Provider	\$25 (deductible waived)	\$40 (deductible waived)	\$35 (deductible waived)	\$40 (deductible waived)	\$50 (deductible waived)	50%	\$35 (deductible waived)	\$40 (deductible waived)	50%
9	Specialist Provider	\$45 (deductible waived)	\$60 (deductible waived)	\$50 (deductible waived)	\$60 (deductible waived)	\$70 (deductible waived)	50%	\$50 (deductible waived)	\$60 (deductible waived)	50%
10	Telehealth	\$0	\$0	\$0	\$0	\$0	50%	\$0	\$0	Not Covered
11	Preventive Services/Immunization	\$0 (deductible waived)	\$0 (deductible waived)	\$0 (deductible waived)	\$0 (deductible waived)	\$0 (deductible waived)	50% (deductible waived)	\$0 (deductible waived)	\$0 (deductible waived)	50% (deductible waived)
12	Well Child Services/Immunization	\$0 (deductible waived)	\$0 (deductible waived)	\$0 (deductible waived)	\$0 (deductible waived)	\$0 (deductible waived)	50% (deductible waived)	\$0 (deductible waived)	\$0 (deductible waived)	50% (deductible waived)
13	Laboratory	\$20	\$20	25%	30%	40%	50%	25%	30%	50%
14	X-Rays	\$100	\$100	25%	30%	40%	50%	25%	30%	50%
15	Inpatient Hospital	20% coinsurance after deductible	20% coinsurance after deductible	\$700 per admission	\$1,250 per admission	\$1,750 per admission	50%	\$700 per admission	\$1,250 per admission	50%
16	MRI, MRA, CAT Scan, and PET Scan	\$250 per test per day	\$250 per test per day	25% up to maximum of \$250 per test	25% up to maximum of \$300 per test	35% up to maximum of \$300 per test	50%	\$250 copay per type of scan per day, and plan pays 100%	\$300 copay per type of scan per day	50%
17	Outpatient Surgery	\$500 copay	\$500 copay	25% \$250 per visit	25% \$500 per visit	35% \$700 per visit	50%	\$250 copay/visit, plus 25% coinsurance	\$500 copay/visit, plus 25% coinsurance	50%
18	Maternity Hospitalization	\$1000 per admission	\$1000 per admission	\$500 per admission	\$1,000 per admission	\$1,400 per admission	50%	\$500 per admission	\$1,000 per admission	50%
19	Routine Nursery Care for Newborns	No Copay	No Copay	No Copay	No Copay	No Copay	50%	No copay	No Copay	\$50%
20	Emergency Room Visit	20% coinsurance after deductible	20% coinsurance after deductible	\$300	\$325	\$325	\$325	\$300	\$325	\$325
21	Urgent Care Center	\$100 All Inclusive	\$100 All Inclusive	\$60	\$65	\$75	\$75 (after PPO deductible)	\$60	\$65	\$75
22	Mental Health/Substance Abuse OutPatient	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	50%
23	Mental Health/Substance Abuse InPatient	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	50%
24	Chiropractic, Acupuncture	\$50 (deductible waived) (up to 25 combined visits per plan yr)	\$50 (deductible waived) (up to 25 combined visits per plan yr)	\$55 (deductible waived) (up to 25 combined visits per plan yr)	\$60 (deductible waived) (up to 25 visits combined per plan yr)	\$70 (deductible waived) (up to 25 visits combined per plan yr)	50% (up to 25 visits combined per plan yr)	\$55 (deductible waived) (up to 25 visits combined per plan yr)	\$60 (deductible waived) (up to 25 visits combined per plan yr)	50% (up to 25 visits combined per plan yr)
25	Naprapathic Services, Massage Therapy	\$55 (deductible waived) \$0 (behavioral health) (up to 25 combined visits per plan yr)	\$55 (deductible waived) \$0 (behavioral health) (up to 25 combined visits per plan yr)	\$60 (deductible waived) \$0 (behavioral health) (up to 25 combined visits per plan yr)	\$65 (deductible waived) \$0 (behavioral health) (up to 25 combined visits per plan yr)	\$75 (deductible waived) \$0 (behavioral health) (up to 25 combined visits per plan yr)	50% (up to 25 visits per plan yr) \$0 (behavioral health)	\$60 (deductible waived) \$0 (behavioral health) (up to 25 visits per plan yr)	\$65 (deductible waived) \$0 (behavioral health) (up to 25 visits per plan yr)	50% (up to 25 visits per plan yr)
26	Durable Medical Equipment	20% coinsurance after deductible	20% coinsurance after deductible	25%	25%	35%	45%	25%	28%	45%
27	Chemotherapy and Radiation Therapy	Plan pays 100% after deductible	Plan pays 100% after deductible	No Copay in Physicians Office	\$55 per visit (deductible waived)	\$65 per visit (deductible waived)	50%	Prior Authorization (PA) required	Prior Authorization (PA) required	Prior Authorization (PA) required
28	Home HealthCare	\$45 copay per visit	\$75 copay per visit	\$45 copay per visit	\$55 (deductible waived)	\$65 per visit	50%	\$45 Physician (deductible waived) no copay for nursing services	\$55 (deductible waived)	50%
29	Hearing Aids	No copay up to \$2500 per ear; once every 3 yrs (36 months)	No copay up to \$2500 per ear; once every 3 yrs (36 months)	No copay up to \$2500 per ear; once every 3 yrs (36 months)	No copay up to \$2500 per ear; once every 3 yrs (36 months)	No copay up to \$2500 per ear; once every 3 yrs (36 months)	50% No copay (deductible waived)	(age 22 and older \$5,000 maximum per 36 months)	(age 22 and older \$5,000 maximum per 36 months)	50%
30	Physical, Occupational, & Speech Therapy	\$25 (deductible waived)	\$40 (deductible waived)	\$35 (deductible waived)	\$40 (deductible waived)	\$50 (deductible waived)	50%	\$35 (deductible waived)	\$40 (deductible waived)	50%
31	Hospice	No Copay	No Copay	No Copay	No Copay	No Copay	50%	No copay	No copay	50%

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33	CVS caremark -STATE OF NM 2022 (Pharmacy Benefit Manager)									
34					Retail (30 Day Supply)***			Mail Order (90 Day Supply)		
36	Out of Pocket			Combined prescription and medical OOP maximum						
37	Deductible**			\$50 Individual/ \$100 Family only on Non-Generics (applies to Medical annual OOP Max)						
38	Generic			\$6.00			\$17.00			
39	Brand (Preferred)			30% (\$35 min/ \$95 max)			\$120.00			
40	Brand (Non-Preferred)			40% (\$60 min/ \$130 max)			\$155.00			
41	Specialty Medications (30 day supply) must move to mail order after 2 fill at retail			\$60 Generic \$85 Preferred Brand \$125 Non-preferredBrand <small>*Contact Prudent RX to confirm eligibility for co-pay assistance</small>			\$60 Generic \$85 Preferred Brand \$125 Non-preferred Brand <small>*Contact Prudent RX to confirm eligibility for co-pay assistance</small>			
42	**DEDUCTIBLE: \$50 PER INDIVIDUAL/\$100 FAMILY APPLIES TO Formulary and Non-Formulary Only									
43	***Three retail fills are allowed on maintenance medications before your copay will increase to the mail order copays shown above (for a 30 day supply).									
44	Note: If you obtain a brand name drug when a generic equivalent is available, you are responsible for the applicable brand name co-payment plus the cost difference between the brand-name drug and the generic drug. This does not apply to specialty medications.									

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46	DELTA DENTAL PPO-STATE OF NM 2022									
47										
48		Services		<u>PPO Provider</u>		<u>Premier Provider</u>		<u>Non-Participating Provider</u>		
49		Diagnostic & Preventive Services		100% (not subject to deductible)		100% (not subject to deductible)		100% (not subject to deductible)		
50		Basic Services		80% Plan Pays		80% Plan Pays		55% Plan Pays		
51		Major Services		60% Plan Pays		60% Plan Pays		35% Plan Pays		
52										
53	<u>Calendar Year Deductibles</u> \$50 per person, \$150 per family Deductible does not apply to Diagnostic, Preventive or Orthodontic Services									
54										
55	<u>Orthodontic Services</u> Children up to 18 - 75% up to \$2,000.00 Lifetime Maximum Adults 18 and over - 60% up to \$1,750.00 Lifetime Maximum									
56										
57	<u>Benefit Annual Maximum - Calendar Year</u> \$1,750.00 per enrolled person - per calendar year									
58										
59	Please contact Delta Dental for service descriptions or further details at 1-877-395-9420									
60										
61										